Health Insurance Affordability Options: Requests to JCHC

COMMISSION MEETING
NOVEMBER 16, 2020

Briefing Agenda

- Topics referred to the JCHC in 2020
- Federal avenues to insurance market reform
- Key questions for consideration in future JCHC work
- Appendices
  I. Section 1332 Waivers (ACA) – slide 12
  II. Association Health Plans – slide 17
  III. Public Options – slide 24
  IV. Basic Health Program – slide 27
  V. Medicaid Section 1115 Waiver – slide 31
  VI. Individual Market Overview – slide 33
  VII. Background Data on Coverage, Poverty, and the Uninsured – slide 42

Three study topics discussed this year - all related to affordability and access to health coverage

Commonwealth Care Health Benefits Program

SB 364
Senator Dunnavant

Affordable coverage for people under 200% of poverty

Delegate Hope

Creation of a "public option"

HB 5083
Delegate Samirah

Commonwealth Care Health Benefit Program (SB 364, 2020)

- Bill overview
  - Creates a division within the State Corporation Commission (or nonprofit entity)
  - Division sponsors association health plans sold through the program
  - Replace health benefit exchange using Association Health Plans (AHPs)
- Implementation contingent on approval of Section 1332 state innovation waiver
- Ongoing costs of the program covered by:
  - Premiums paid by plan members
  - Federal funds from approval of Section 1332 state innovation waiver
- Requirements for AHPs participating in the program
  - Not less than coverage offered by a large group plan subject to ERISA
  - At least 1 plan providing ACA level coverage meeting affordability requirements or complies with “guardrail” requirements

Affordable coverage for people under 200% of poverty (three options)

- Adoption of ACA Basic Health Program (Section 1331, ACA)
- Medicaid expansion through Section 1115, Title XIX, waiver and possible Section 1332, ACA, waiver
- State funding to assist low-income individuals with cost sharing for plans sold on the health benefit exchange

Public option (HB 5083, Special Session 1, 2020)

- Goal is a consumer friendly design
  - Affordable premiums
  - Low deductibles
  - Maximize ACA subsidies
- Meet ACA qualified health plan benefit requirements
- Provider reimbursement rates limited to Medicare fee-for-service rates
- Health plans offered on the exchange
  - Operated under contracts with the Department of Medical Assistance Services (DMAS)
  - Sold by licensed insurers

NOTE: see Appendix III, slide 22 for additional details on public options

Options are targeted at individual market and the uninsured

About 270,000 Virginians enrolled in individual market insurance plans in 2020

- 88 percent are under 400% of federal poverty level and eligible for federal tax credits for premium assistance (APTC)
- 45 percent are under 200% of federal poverty level

748,000 Virginians were uninsured in 2018 (prior to Medicaid expansion)

Virginia has a variety of avenues to implement insurance market reforms

- **Section 1332 Innovation Waiver, ACA** (Appendix I, slide 12)
  - Reviewed by 2 federal agencies – CMS and Department of Treasury
  - Funds to state based on savings to federal government

- **Association Health Plans** (Appendix II, slide 17)
  - Plans organized by association members
  - Limited regulatory oversight

- **Section 1331 Basic Health Program, ACA** (Appendix IV, slide 27)
  - People under 200% of poverty; lawfully present non-citizens ineligible for Medicaid
  - Funds to state equal 95% of what would have been used for APTC/Cost Sharing

- **Section 1115 Waiver Title XIX - Medicaid** (Appendix V, Slide 31)
  - Promotes flexibility and creativity in state implementation of Medicaid

Every option to make coverage more affordable needs to be studied in detail

Actuarial studies	• Enrollment options • Benefit design • Provider reimbursements • Costs to state and enrollees
Impact analysis	• Churning: income changes that cause enrollees to fluctuate between different levels of coverage • Crowd-out: unintended consequence, substitution of private coverage with less costly public coverage • Adverse selection: high-risk or sick individuals delay or do not purchase coverage until they need it and then choose most comprehensive coverage while healthy people choose lower cost options or do not enroll
Addressing "income cliffs"	• Low income enrollees' out-of-pocket costs (138% to 200% of poverty) • 400% and over availability of affordable coverage

JCHC role in future studies

- Study the implementation and effectiveness of strategies used in other states
  - Insurance options similar to those referred to JCHC
  - Strategies to increase insurance plan participation in the market
  - Strategies to increase market enrollment
- Meet with state agencies and stakeholders to understand implementation considerations and perspectives on different options
- Assess the impact of each option
- Determine next steps for policy options, including:
  - Parameters for actuarial studies
  - Necessary legislation and federal pathways to implement reforms

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APPENDIX - I

Section 1332 Waivers (ACA)

What is a Section 1332 (ACA) waiver and how does it work?

- Provides states with the ability to receive exemptions from specific parts of the ACA
  - Regulation of qualified health plans
  - Exchange operations and administration
  - Cost-sharing reductions
  - Premium tax credits and the individual and employer mandates

- Allows states to receive federal funds equal to the amount that would have been paid for advanced premium tax credits/cost sharing reductions based on federal savings

- Proposed reforms must meet specific "guardrails":
  - Provide access to coverage at least as comprehensive and affordable, including cost sharing protections
  - Cover a comparable number of residents as if the waiver did not exist
  - Must be federal budget neutral - includes federal administration; requires 10-year budget plan

- States must enact a state law permitting the waiver application

- The waiver application must go through both a state and federal public comment process

Section 1332 waiver approval is a two-step federal process

- CMS and the Department of Treasury review waiver applications together for completeness and approval
- Treasury determines the amount of funding states receive based on their model
- Waiver rules define how states must meet ACA guardrails; new rules issued in 2018 relaxed the guardrail review process
  - Changed focus from actual coverage to access to coverage - *even as it applies to comprehensive and affordable*
  - Changed focus from waiver effects on vulnerable populations to aggregate effects on the state
  - Expanded types of plans that can be part of a waiver
  - Changed annual changes to federal deficit to total deficit over all 10-years combined
  - Allows states to use existing authorization laws to submit additional waivers
- The law establishing the guardrails has not changed, just the implementing regulations

15 of 16 approved waivers allow states to operate reinsurance programs

- 15 approved reinsurance through Section 1332 waivers
  - *AK, CO, DE, GA, ME, MD, MN, MT, NH, NJ, ND, OR, PA, RI, WI*

- Hawaii is the only state to obtain a different type of Sec. 1332 waiver
  - maintains 1974 state law for small businesses in lieu of small business health insurance marketplace (the "SHOP")

- 7 states withdrew waiver applications - most due to incomplete information and/or inability to meet requirements of law related to federal budget neutrality *(CA, ID, IA, MA, OH, OK, VT)*

- 6 states have authorizing legislation but no waiver application *(IN, KY, NV, NM, TX, VA)*

- Georgia waiver was approved on November 2, 2020 – two part waiver application
  1. reinsurance (approved but delayed due to cost)
  2. replace marketplace with privately operated direct enrollment marketplace that includes a new low cost limited coverage plan level

Source: Center for Consumer Information and Insurance Oversight (CCIIO) and NCSL.

Reinsurance waivers are more likely to be approved by CMS and Treasury

- States are stepping in where the federal government left off with three ACA programs that encouraged insurers to:
  - Enroll sick individuals
  - Maintain affordable and stable premiums until a claims history developed
  - Participate in the Market Place

- The programs were:
  - Reinsurance (ended in 2016) - payments to insurers for high-cost claims
  - Risk Corridors (ended in 2016, funding blocked by Congress) – limited insurers' gains and losses. Payments made with a combination of federal funds and insurer funds based on claims experience
  - Risk Adjustment (permanent) - insurers that enroll a relatively larger share of high-risk enrollees receive payments from those insurers with a relatively low share of high-risk enrollees

- Reinsurance programs have been the most common among other states, and require both state and federal funding

APPENDIX - II

Association Health Plans

Association health plans (AHP) prior to 2018 were regulated at the state and federal level

- Allow small employers to band together to purchase health coverage available to large employers
- Can either be fully-insured or self-insured
- Fully-insured: contracts with commercial insurance company to underwrite health risks
- Self-insured: association assumes risk for paying claims
  - — Obtains stop-loss insurance for high cost medical claims
  - — Exempt from state premium taxation
  - — May be subject to state-specific benefit mandates and premium rating regulations
- Federal rules require AHP to be “bona-fide” to be considered large group plan
  - — Does the association exist for a purpose other than providing benefits?
  - — Do employer members have a close enough relationship to be essentially a single common entity?
  - — Do employer members control the health plan in form and substance?

(Source: Milliman Whitepaper. “After the Final Rule.” August 2018; and Bianchi, Alden. “Association Health Plan Perspectives.” July 2018.)

ACA requirements for “bona-fide” Association Health Plans

- Considered Large Group Plans
- Exempt from essential health benefits rules and small group age rating requirements
- Permitted to charge higher premiums based on health claims experience of a particular member *(may include gender, age, and occupation)*
- Cannot deny coverage or discriminate based on health status
- Must comply with out-of-pocket maximums
- Cannot impose lifetime limits on coverage
- Employers with 15 employees or more must offer maternity benefits

AHPs are subject to large-group rules

Application of ACA Insurance Protections by Market Segment (Fully Insured)			
ACA Market Reform	Individual Market	Small-group Market*	Large-group Market*
Guaranteed issue	Yes	Yes	Yes
Pre-existing condition exclusions prohibited	Yes	Yes	Yes
Out-of-pocket maximums	Yes	Yes	Yes
Annual and lifetime limits prohibited	Yes	Yes	Yes
Preventive services covered without cost-sharing	Yes	Yes	Yes
Essential health benefits	Yes	Yes	**No**
Rating rules	Yes	Yes	**No**
Single risk pool	Yes	Yes	**No**
Risk adjustment program	Yes	Yes	**No**
Medical loss ratio	80%	80%	85%

Source: Corlette, Sabrina, et.al. "New Rules to Expand Association Health Plans, How will they affect the individual market?" The Actuary. May 2018 Web Exclusive.

“Farm Bureau Plan” (Tennessee Model)

- Began in 1993 and went unchallenged by Obama administration following passage of the ACA
- Regulated by the state as “not-for-profit membership organization”
- Explicitly considered “not insurance” therefore outside of state regulation
- Members do not need to be businesses; may not need to be farmers or connected with agriculture
- ACA rules do not apply, including:
  - — essential health benefits
  - — coverage to individuals with pre-existing conditions

“Pathway 2” health coverage created under new 2018 federal rules for Association Health Plans

- Rules make forming and joining an AHP easier
  - Permits sole proprietors, freelancers, self employed to join as both employer and employee
  - Relax “commonality of interest” requirement, allowing for common geography or industry
  - Offer “large group” coverage to all employer members regardless of size
  - States may move forward under new regulations in good faith until final determination in federal court; will not be penalized following court decision

- State regulation of AHPs remains unchanged

- 10 states passed new laws permitting “Pathway 2” or Farm Bureau Plans between 2018 - 2019 *(AZ, FL, NC, AR, HI, IA, KS, KY, OK, SD)*

- There is an ongoing federal court challenge to the new federal rules

Examples of “Pathway 2” and use of “Farm Bureau” AHPs

- North Carolina 2019 law
  - Permits small employers to offer a self-funded or fully insured AHP
  - Organized based on common geography (or the same trade/industry)
  - Includes working owners
  - Requires study of Section 1332 waiver if federal rule is invalidated

- Iowa 2018 law
  - Farm Bureau Plan – sponsored by a local nonprofit agriculture organization
  - Self-funded and not restricted to the agricultural community
  - Defined as “not insurance”
  - Exempt from most state and ACA regulation

APPENDIX - III

Public Options

Public options have common features, enacted in different ways

- Common features
  - — Offered on the health insurance exchange
  - — Operated through public-private partnerships
  - — Use standardized or model health plans
  - — Regulate provider rates

- Planning and implementing a public option is a challenging process
  - — Analysis and actuarial study
  - — Buy-in by providers, insurance companies, and other stakeholders

- Three states have three different ways of implementing a public option
  - — Washington State - State regulated insurance, enacted
  - — New Mexico - Medicaid buy-in program, two years of studies
  - — Colorado – Section 1332 waiver, studied

Example of “Public Option” law in effect for 2021: Washington State’s Cascade Care

- Administered by Washington State Based Exchange and Washington Health Care Authority

- Health carriers operating on exchange must offer state designed standardized silver and gold plan
  - Bronze only if offered in addition to other plans offered
  - Plans must be actuarially sound and affordable (based on premiums, deductibles, other cost sharing)

- Regulated provider reimbursements
  - Total statewide aggregate cap for all providers – 160% of the statewide aggregate paid by Medicare (excludes pharmacy; may be waived starting in 2023)
  - Critical access and sole community rural hospitals – 101% of allowable costs for Medicare
  - Primary care services – 135% of allowable costs for Medicare

- Requires state to develop a plan by 11/15/2020 to provide state subsidies to people at or below 500% FPL
  - Goal: reduce cost of premiums to no more than 10% of income

- Impact reports, analysis, and evaluations due in 2022 and 2023

APPENDIX IV

Basic Health Program
(Section 1331 of the ACA)

Basic Health Programs are authorized in the ACA (Section 1331)

- The Basic Health Program
  - State option to apply and will be approved if all requirements are met
  - Provides coverage stability for individuals below 200% of federal poverty level
  - Coordinated with Medicaid and the Exchange

- Provides a substitute for marketplace coverage for low income people
  - Between 138% and 200% of poverty
  - Lawfully present immigrants not yet eligible for Medicaid
  - Enrollees cannot receive tax credits or cost sharing assistance

- Benefits must be at least as comprehensive and affordable as subsidized coverage in the marketplace
  - Health plans can be standard - covering the ten Essential Health Benefits (EHB), or can include additional benefits
  - Enrollees must be able to select from at least two participating standard health plans

- New York State and Minnesota are only states operating Basic Health Programs (both since 2015)

Basic Health Program administration is flexible

- States choose between Medicaid rules and rules that apply in the marketplace to determine:
  - eligibility
  - health plans that can offer coverage
  - benefit packages
  - enrollment periods and processes
- Federal funds
  - 95% of the premium tax credits and cost sharing that would have been paid to those eligible
  - Funds must be deposited in a trust fund exclusively used for benefits
- State funds
  - Needed to pay for administrative costs
  - States can charge fees and surcharges on health plans
- Provider reimbursements established by state regulation

Example of a BHP: New York State

- Enrollment is mandatory for exchange applicants under 200% of FPL
- Premiums
  - — $0 monthly premium for individuals below 150% of FPL
  - — $20 premium for people with incomes below between 150%-200% of FPL
- Provider network is paid 125% of Medicaid rates (between commercial and Medicaid)
- Federal revenue greater than cost of coverage due to provider rate controls
- Federal money comes in advance, placed in federally required trust fund (can't be used for administrative costs)
- BHP plans pay insurance taxes on premiums to fund the administrative costs of the plan
- 15 health insurance companies participate, mostly Medicaid managed care companies

APPENDIX V

Medicaid Section 1115 Waiver

Expanding Medicaid through Section 1115 waiver

- States apply for exemptions to federal Medicaid and CHIP laws and rules
  - — Approved for multiple years
  - — Funded at state match rate
  - — Must be budget neutral to federal government
  - — Requires public comment and evaluations

- Examples of past waiver usage
  - — Enrollment into Managed Care Organizations
  - — Premium assistance and cost-sharing programs for working poor
  - — Creation of global caps on federal funds for cost control, program predictability
  - — Targeted expanded coverage for long term care and behavioral health and substance abuse

- Examples of possible future use of waivers
  - — Combining Medicaid with marketplace coverage to offset out-of-pocket expenses
  - — Use Medicaid as a public option on the marketplace through premium assistance program

APPENDIX - VI

Individual Market Overview

People apply for health coverage through the health insurance exchange

- One stop online shopping for health care coverage
  - — Operated by federal and/or state agencies
  - — Coordinated with Medicaid to either automatically enroll eligible individuals or refer them to state enrollment process (state choice)
  - — Apply for advanced refundable premium tax credits that offset premiums based on income - household income 100% to 400% of FPL (credit calculation based on cost of 2nd lowest silver plan)

- Participation by insurers requires
  - — Providing minimum essential coverage (EHBs)
  - — Design benefit packages based on levels of cost sharing

- Federal subsidies in Virginia
  - — 88% of ~270,000 applicants eligible for APTC and/or cost share assistance (2020)
  - — In the aggregate VA enrollees receive between $1.5 and $2.0 billion in federal assistance

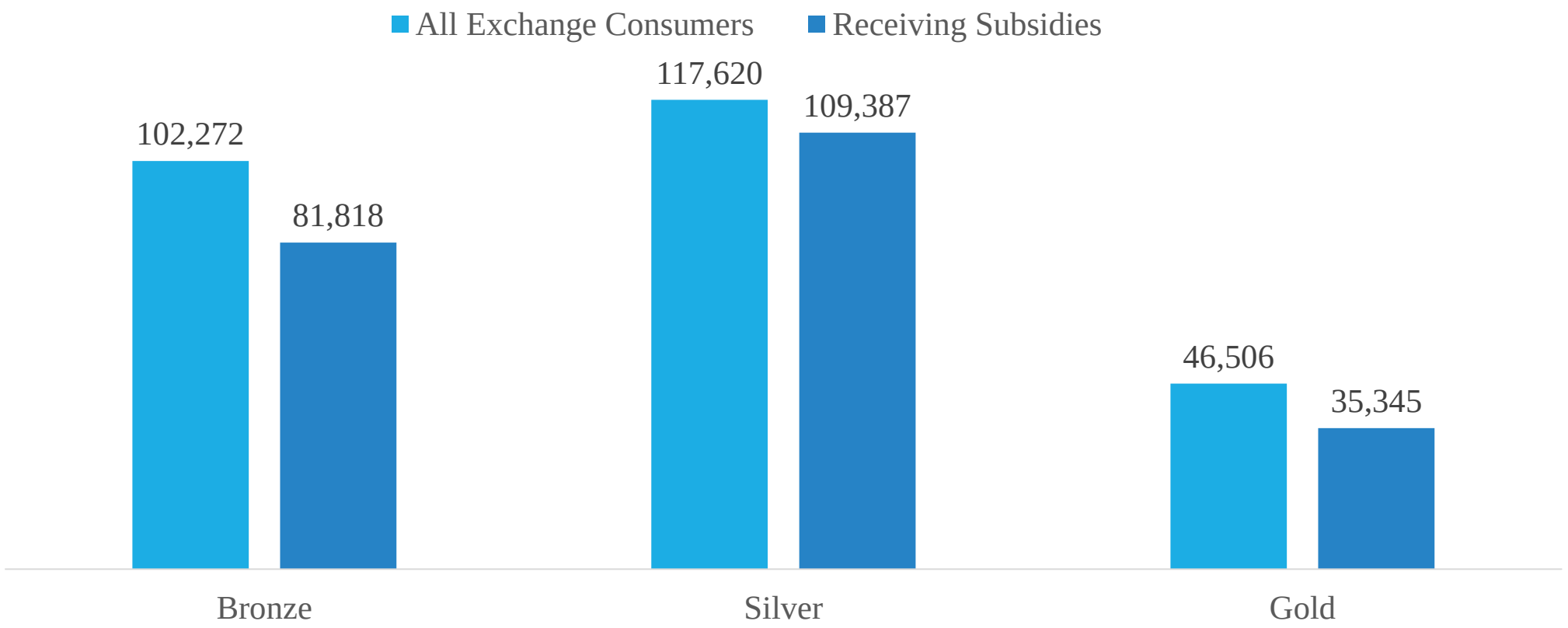
Levels of Cost Sharing for Health Insurance sold on an Exchange		
Plan Level	Insurer Pays	Enrollee Pays
Bronze	60%	40%
Silver	70%	30%
Gold	80%	20%
Platinum	90%	10%

Ten essential health benefits for ACA individual market plans

Ten essential health benefits Individual health plans or plans offered through the Small-group Marketplace	
1. Prescription Drugs	6. Mental Health and Addiction Services
2. Pediatric Services (includes dental, vision)	7. Pregnancy, Maternity, and Newborn Care
3. Preventive and Wellness Services and Chronic Disease Management	8. Ambulatory Patient Services
4. Emergency Services	9. Laboratory Services
5. Hospitalization	10. Rehabilitative and Habilitative Services and Devices

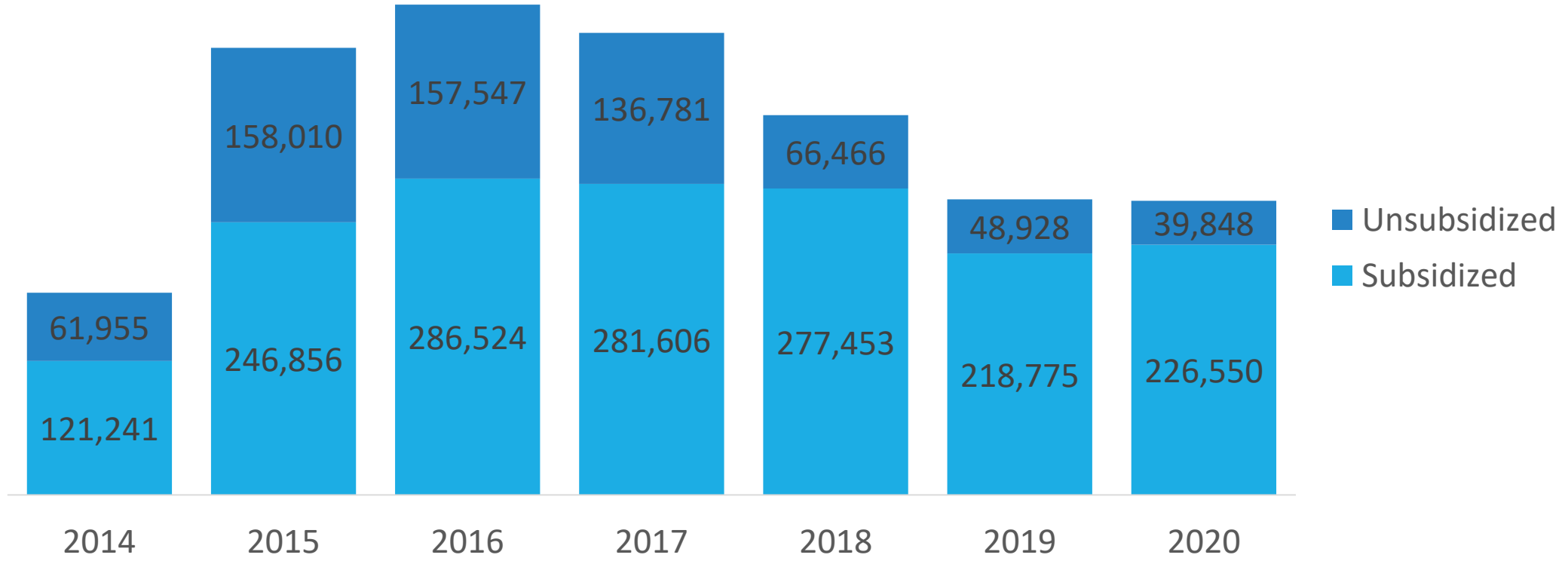
NOTE: States can mandate additional coverage. Large employers who self-insure do not have to provide essential health benefits.

Individual market enrollment by plan level in 2020



Source: CMS Center for Consumer Information and Insurance Oversight

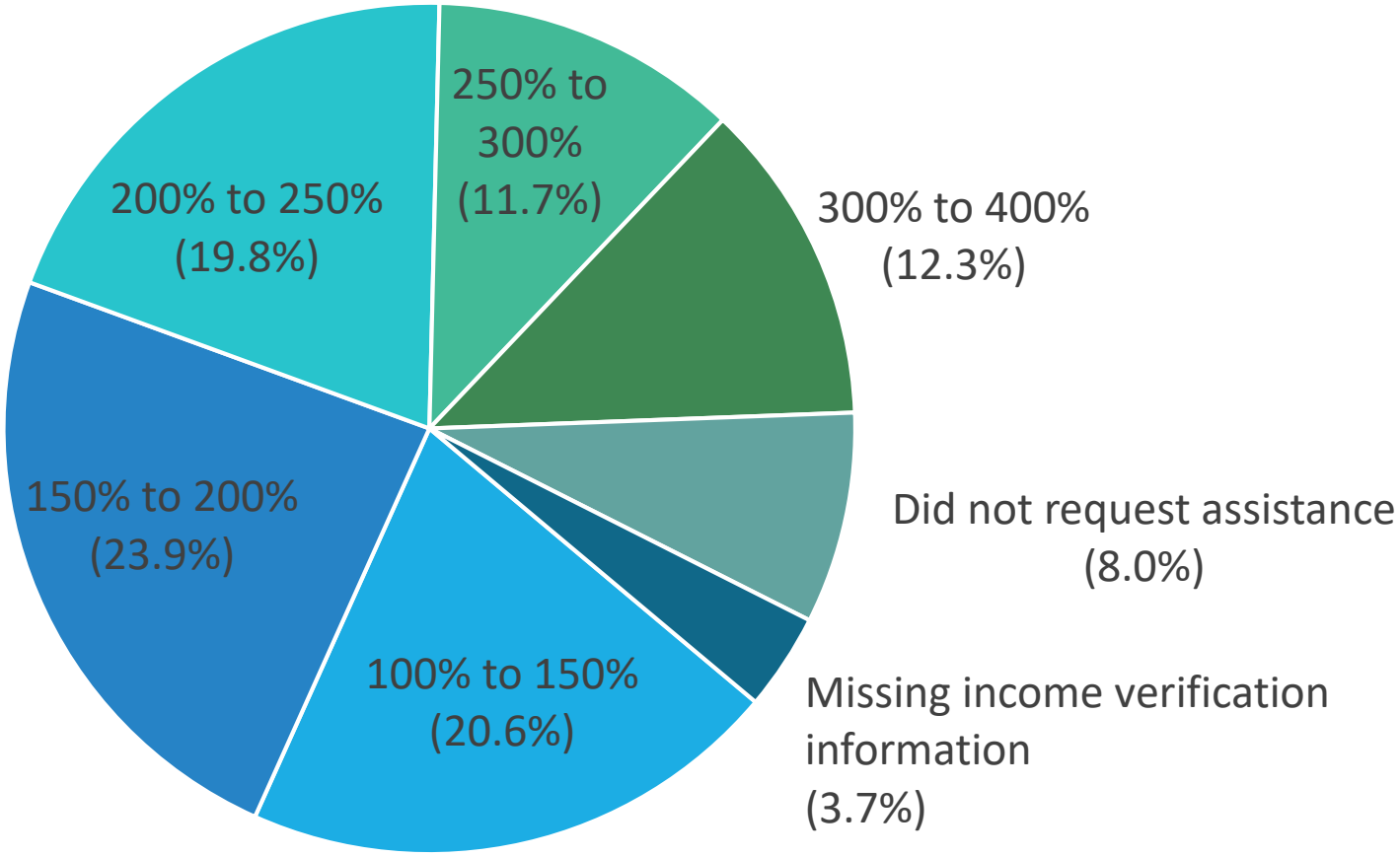
Increased premiums on the marketplace are driving out unsubsidized individuals



Source: CMS. Trends in Subsidized and Unsubsidized Enrollment. October 9, 2020.

Individual market enrollment by poverty level (2020)

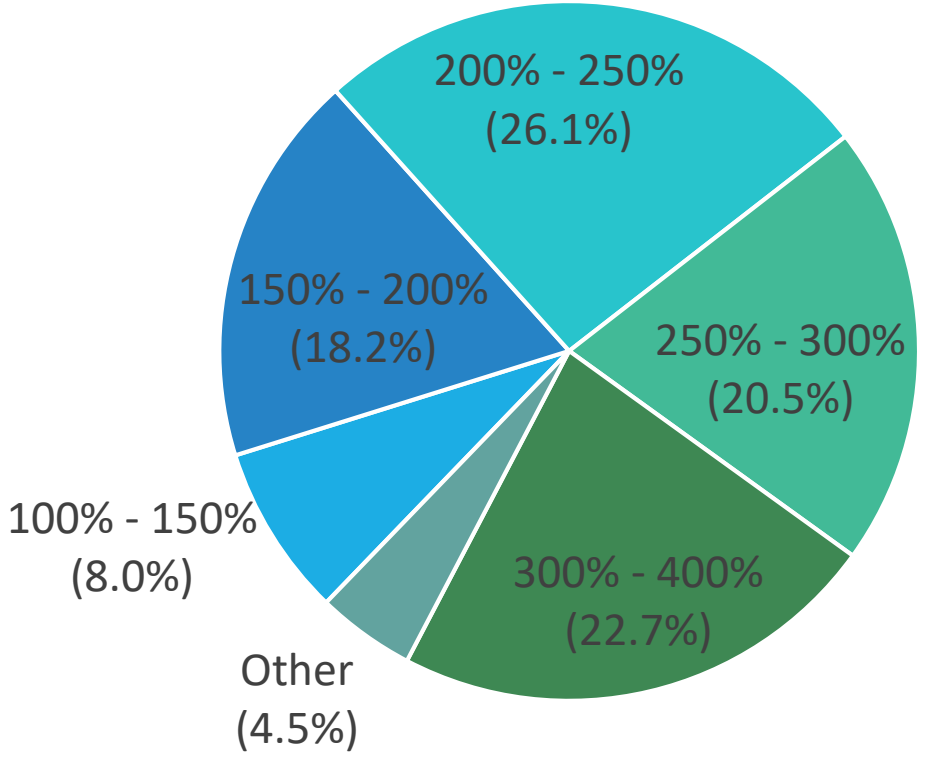
- 64.3% of market place enrollees have income at or below 250% of poverty
- 44.5% are at or below 200% of poverty



Source: CMS Center for Consumer Information and Insurance Oversight (CCIIOhttps://www.cms.gov/CCIIO/Resources/Data-Resources/marketplace-puf

Bronze Plan enrollment by poverty level (2020)

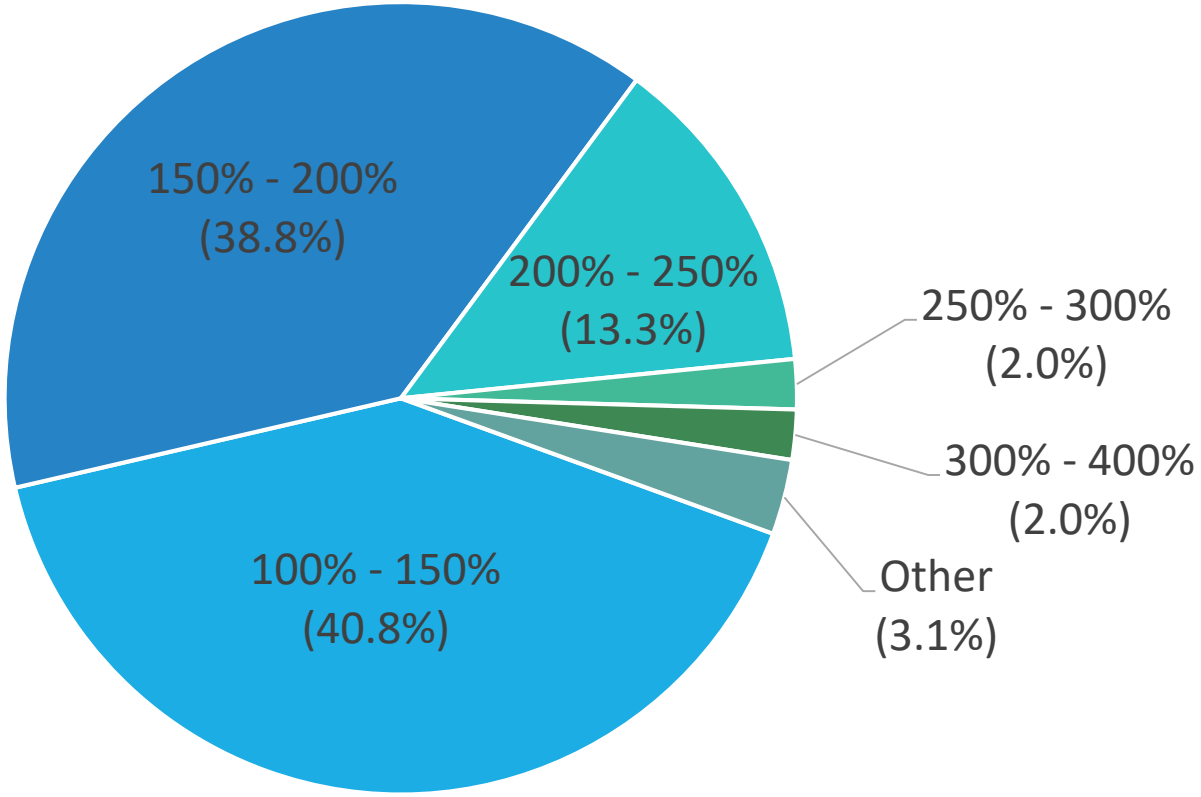
- 52.3% of Bronze Plan enrollees have income at or below 250% of poverty
- 26.2% are at or below 200% of poverty



Source: CMS 2020 Marketplace Open Enrollment Period Public Use Files

Silver Plan enrollment by poverty level (2020)

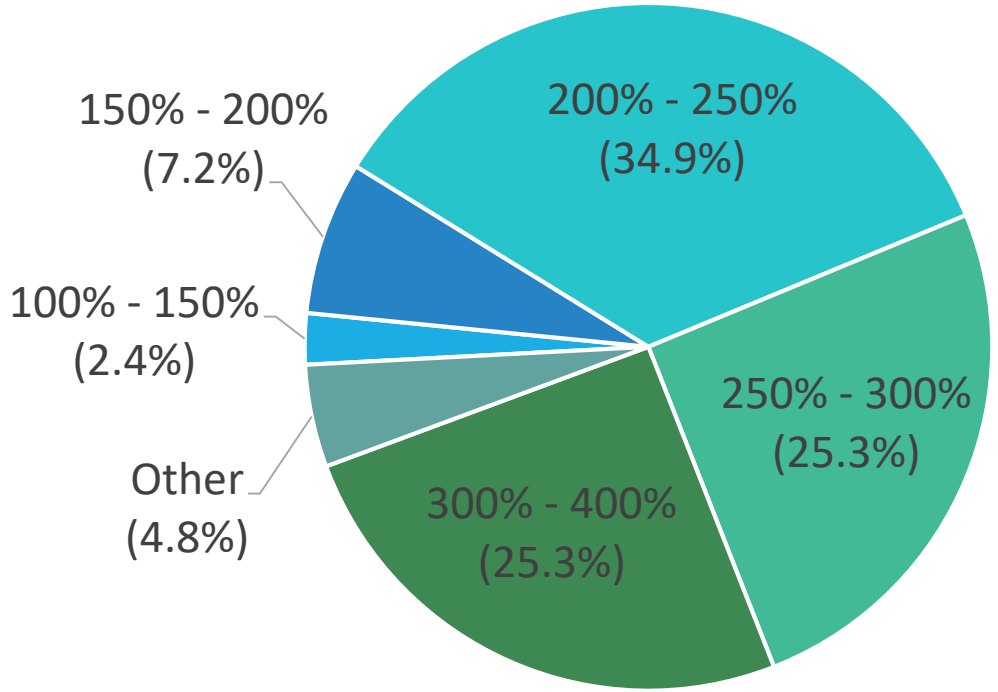
- 92.9% of Silver Plan enrollees have income at or below 250% of poverty
- 79.6% are at or below 200% of poverty



Source: CMS 2020 Marketplace Open Enrollment Period Public Use Files

Gold Plan enrollment by poverty level (2020)

- 44.5% of Gold Plan enrollees have income at or below 250% of poverty
- 9.6% are at or below 200% of poverty



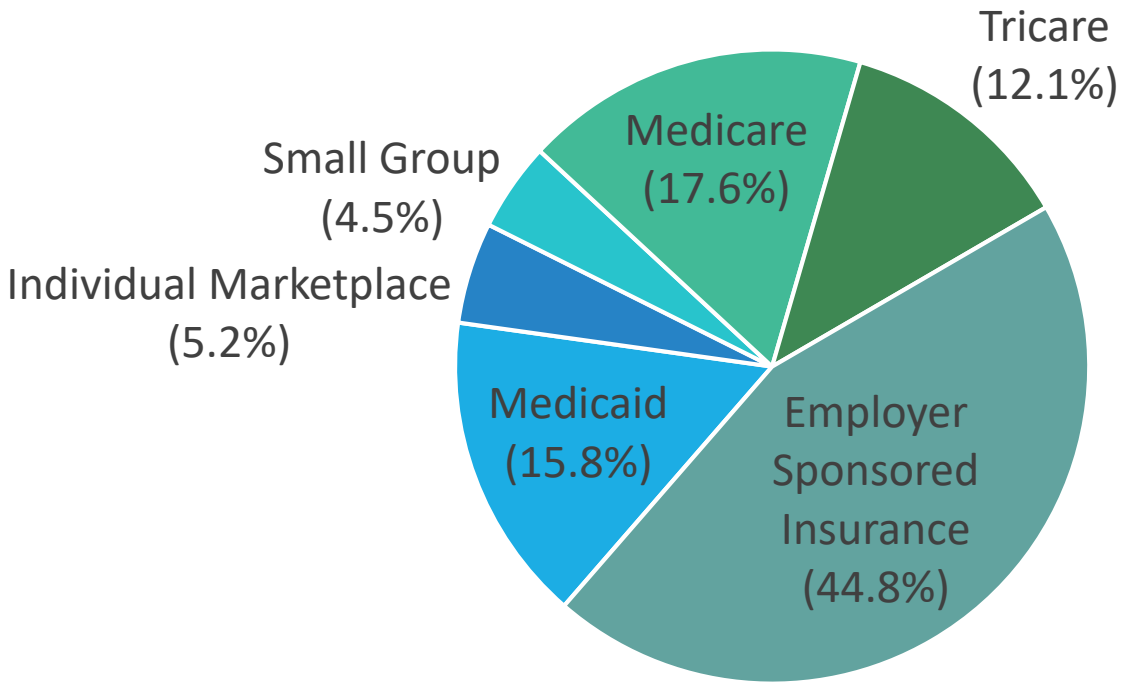
Source: CMS 2020 Marketplace Open Enrollment Period Public Use Files

APPENDIX - VII

Background Data on Coverage, Poverty and the Uninsured

Enrollment in all major categories of health coverage (2018)

State can directly regulate 25.5% of health coverage based on enrollment (small group, individual and Medicaid, 2018)



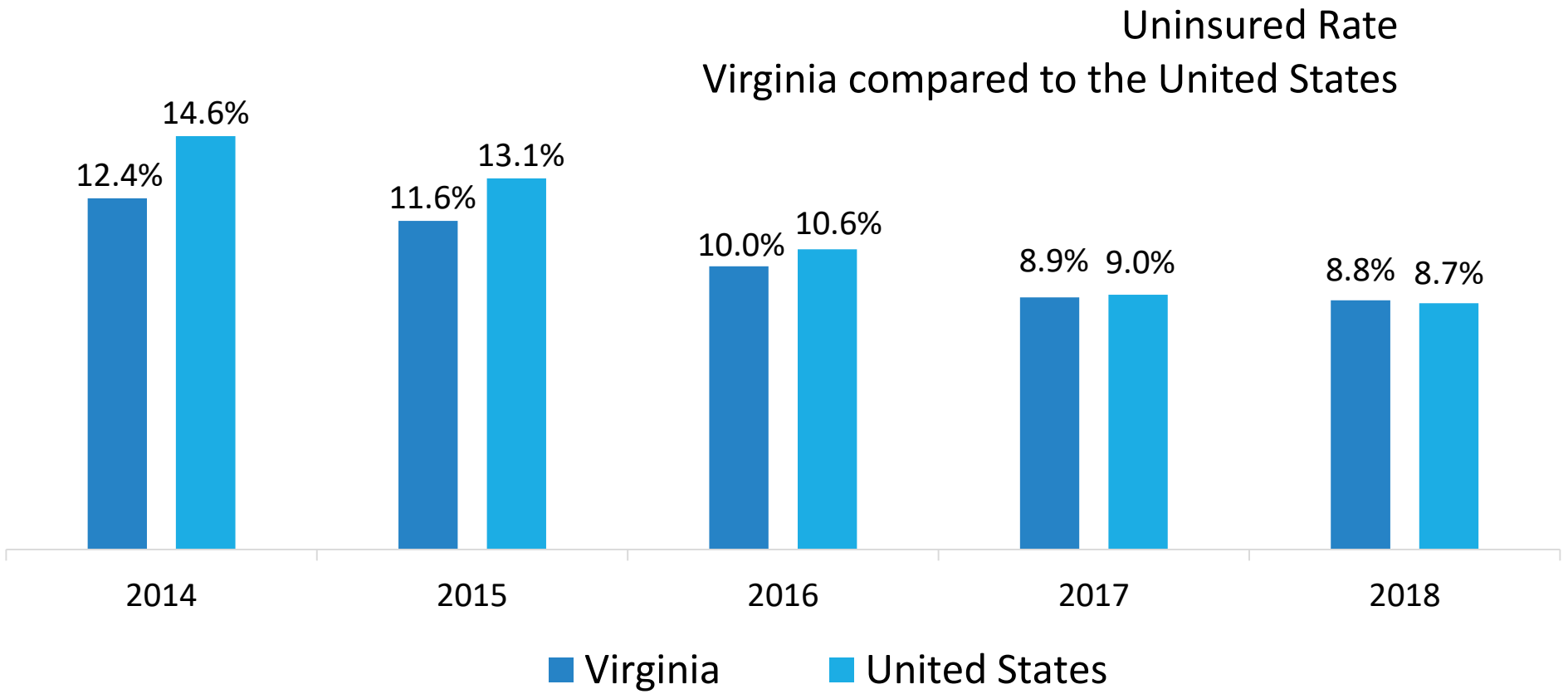
Source: JCHC staff analysis of data from the Department of Medical Assistance Services, CMS Administrative Enrollment Statistics, Center for Consumer Information and Insurance Oversight (CCIIO), Military Health System, and Virginia Bureau of Insurance.

Poverty calculations that drive coverage for individuals and families by hourly income

Family Size	Hourly Income / Annual Income (2020)		
	138%	200%	400%
2	$11.44 / $23,795	$16.58 / $34,486	$33.15 / $68,952
3	$14.41 / $29,973	$20.88 / $43,430	$41.77 / $86,882

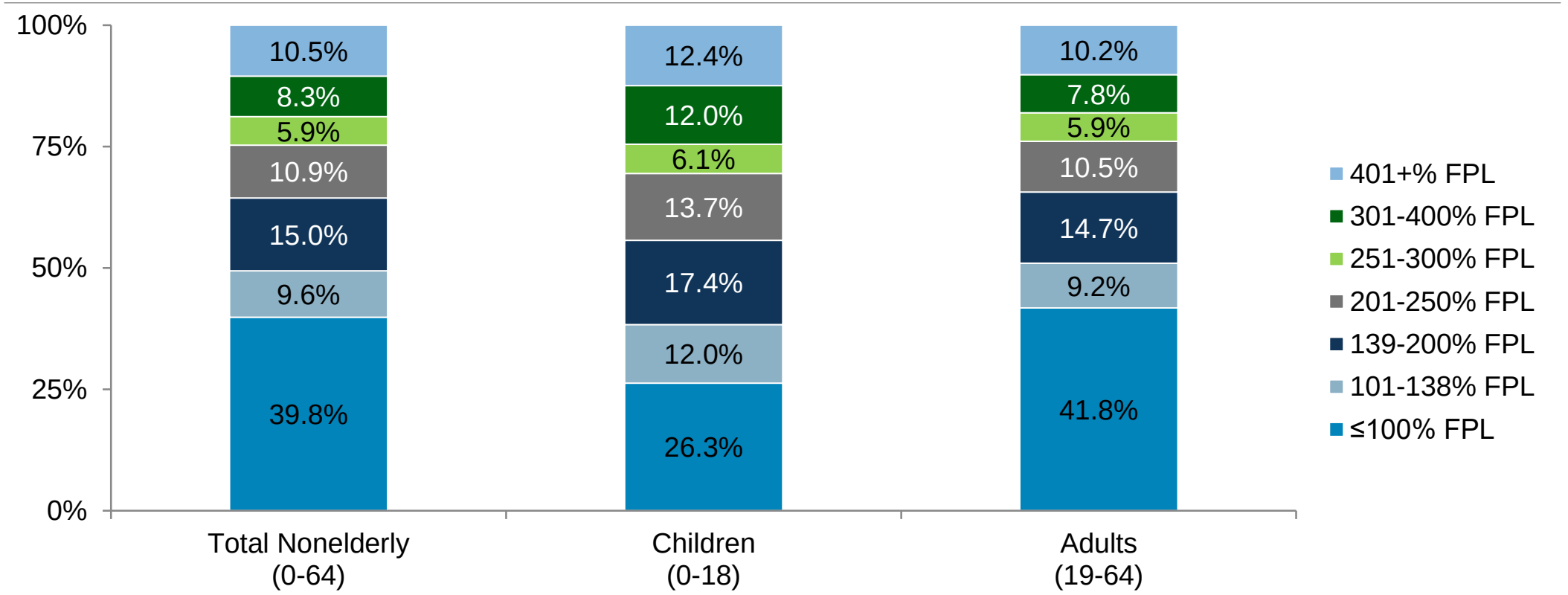
Source: https://aspe.hhs.gov/poverty-guidelines

Percent of uninsured in Virginia by year



Source: Uninsured Percent, America Health Ranking. Annual Reports

A little more than 10% of the nonelderly uninsured had a family income ≥400% FPL while 40% were ≤100% FPL in 2018



Source: Urban Institute, February 2020. Based on the 2018 American Community Survey (ACS) data from the Integrated Public Use Microdata Series (IPUMS). The estimates reflect Urban Institute adjustments for potential misreporting of coverage.